Department of Health & Human Services
DHHS
NEBRASKA
Department of Health and Human Services
Licensure Unit / Office of Rehab and Com. Services
PO Box 94986
Lincoln, Nebraska 68509
402-471-2299 or 800-422-3460 x 1-1

RENEWAL NOTICE

YOUR LICENSE **AS A PARAMEDIC EXPIRES 12/31/2010. This document must be postmarked on or before 12/31/2010 to avoid the expiration of your license. If you do NOT renew your license by the expiration date, you may not continue to practice. If you continue to practice you will be subject to an administrative penalty of $10.00 per day up to $1,000.00.**

NAME: _____

ADDRESS: _____

_____

_____

LICENSE #

_____

□ Active No Fee

□ Inactive No Fee

□ Active/Military No Fee

TWO YEAR RENEWAL

NAME & ADDRESS CHANGES: If your name or address is incorrect, cross out incorrect information and print correction. For name changes, you must submit a photocopy of marriage certificate, court order, etc. If not submitted, the license will be issued in the name as printed above.

INACTIVE means that you cannot practice but may represent yourself as having an inactive license. To change from inactive to active status you MUST contact this office for an application and meet the renewal requirements which are in effect at the time the status change is requested. Completing continuing education hours is not required to request inactive status.

I hereby attest that I have a current CPR card and have met ONE of the following: (Complete only A, B, C, or D)

_____ **A. CERTIFICATION OF CONTINUING EDUCATION HOURS**

I have completed at least 60 hours of continuing education, and documentation by a physician or qualified physician surrogate of demonstrated proficiency in peripheral IV administration, drug administration, cardiac skills and endotracheal intubation in a clinical, out of hospital or educational setting during the time period January 1, 2008 through December 31, 2010 Thirty hours (30) must be in the subject matter of the Emergency Medical Technician course and thirty hours (30) must be in the subject matter of the Emergency Medical Technician-Paramedic course.

OR

_____ **B. VERIFICATION BY PHYSICIAN MEDICAL DIRECTOR OR QUALIFIED PHYSICIAN SURROGATE:**

I verify that the above named applicant is qualified for renewal as a PARAMEDIC defined in Statues, 38-1217, Relating to Emergency Medical Services Practice Act. I further attest that the documentation that shows the skill competency for this level of license is available for inspection.

Applicant's Licensed Service Affiliation _____

Medical Director or Physician Surrogate Signature _____ Date _____

OR

_____ **C. VERIFICATION OF NATIONAL REGISTRY CERTIFICATE**

I have a current Paramedic certification from the National Registry of Emergency Medical Technicians (Please attach photocopy)

OR

_____ **D. PASSAGE OF THE WRITTEN ASSESSMENT EXAM.**

I have taken/passed the written assessment exam on DATE: _____. (Please attach photocopy of results).

CONTINUING COMPETENCY AUDIT: If you are randomly selected for an audit to provide proof of your continuing education, you will be notified by mail at a later date. Retain all documentation of continuing education activities that you completed for the renewal of your license in this renewal cycle. Licensees are advised to retain all documentation of continuing education activities for at least four (4) YEARS AFTER THIS RENEWAL. DO NOT SUBMIT CONTINUING EDUCATION CERTIFICATES TO THIS OFFICE UNLESSS YOU RECEIVE AN AUDIT LETTER.

WAIVER: If you **have not** completed the continuing education requirement and wish to apply for a partial or total waiver of the continuing education requirement of continuing education, please check the reason for said request:

_____**I am requesting a waiver** of _____ continuing education hours. Check applicable reason for waiver below.

_____ I have served in the regular armed forces of the United States during part of the thirty-six (36) months preceding the certification renewal date and request my continuing education requirements be waived. (You **MUST** provide official documentation of armed forces service, such as active duty orders or a letter from your immediate superior officer.)
_____ I have suffered a serious or disabling illness or physical disability during the credentialing period immediately preceding the renewal date, which prevented completion of the continuing competency requirements. (Attach a statement from treating physician(s) stating that you were injured or ill, the duration of the illness or injury and of the recovery period, and that you were unable to attend continuing education programs during this period.)
_____ I was first licensed after January 1, 2007.

Documentation (if requested above) must be provided to support your request for waiver of continuing education. If the specified documentation is not submitted, review and processing of your license renewal cannot occur.

YOU MUST COMPLETE THE FOLLOWING QUESTIONS/INFORMATION: To renew your license, you must have a valid social security #, an Alien Registration #, or a Form I-94 # and you must answer the questions below. **Answer each of the following questions with regard to the time period since your last renewal; or if you were initially licensed after 01/01/2007.**

1	Do you have a valid Social Security Number, Alien Registration Number, and/or I-94 Number? If yes, report below. Certain applicants may have both a SSN and an A# or I-94 number, and if so, must report both.		☐ Yes ☐ No
	SOCIAL SECURITY NUMBER #		
	ALIEN REGISTRATION #		
	FORM I-94 (ARRIVAL-DEPARTURE RECORD)		
	Social security numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.		

If you answer NO to questions 2, 3 and/or 4, you must provide an explanation.		
2	Are you of good character?	☐ Yes ☐ No
3	Have you met the continuing competency requirements for your profession or applied for a waiver of those requirements?	☐ Yes ☐ No
4	Do you have the mental and physical capacity to practice?	☐ Yes ☐ No

If you answer YES to any of questions 5-18, you must provide an explanation		
5	Have you committed any immoral or dishonorable acts that would evidence unfitness to practice your profession?	☐ Yes ☐ No
6	Have you abused or become dependent on or actively addicted to alcohol, any controlled substance, or any mind-altering substance?	☐ Yes ☐ No

7	Have you been convicted in any jurisdiction (State(s) of any misdemeanor or felony which has a rational connection with your fitness or capacity to practice? If you answer **YES** to this question, you must request the following documents be sent directly to this office: • A list of any misdemeanor or felony convictions; • A copy of the court record, which includes charges and disposition; • Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions the applicant has taken to address the behaviors/actions related to the convictions; • All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and • A letter from the probation officer addressing probationary conditions and current status, if the applicant is currently on probation.		□ Yes □ No
8	Have you practiced your profession:	Fraudulently? Beyond its authorized scope? With gross incompetence or gross negligence? In a pattern of incompetent or negligent conduct?	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No
9	Have you practiced while your ability to do so was impaired by alcohol, controlled substances, drugs, mind-altering substances, physical disability, mental disability, or emotional disability?		□ Yes □ No
10	Have you permitted, aided, or abetted the practice of any profession by a person not credentialed to do so?		□ Yes □ No
11	Do you hold a credential that was issued by another jurisdiction (State(s)) to provide health services, health-related services, or environmental services in another jurisdiction? Has any credential(s) been denied, refused renewal, or disciplined by another jurisdiction(s)? **If yes,** please provide a list of any disciplinary actions taken against your credential and a copy of the disciplinary action(s), including charges and disposition.		□ Yes □ No □ Yes □ No
12	Have you been denied the right to take a Credentialing Examination?		□ Yes □ No
13	Have you used untruthful, deceptive, or misleading advertising?		□ Yes □ No
14	Have you been convicted of fraudulent or misleading advertising, or of violating the Uniform Deceptive Trade Practices Act?		□ Yes □ No
15	Have you unlawfully distributed intoxicating liquors, controlled substances, or drugs?		□ Yes □ No
16	Have you invaded a field of practice for which you are not credentialed?		□ Yes □ No
17	Have you violated:	• The Uniform Credentialing Act? • Mandatory Reporting Regulations? • The Uniform Controlled Substances Act?	□ Yes □ No □ Yes □ No □ Yes □ No
18	Have you committed any acts of unprofessional conduct relating to the practice of your profession? (Refer to the practice act and regulations for out-of-hospital emergency medical care provider.)		□ Yes □ No

19	Are you with a service(s)? **If you answered "Yes" provide the name(s) of each service you are currently affiliated with.** Service Name _____ Service Name _____ Service Name _____	☐ Yes ☐ No

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Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §§38-129 and 4-108 through 4-114, I attest as follows:

Please check the appropriate box(s) below:

- ☐ I am a citizen of the United States
- ☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act
- ☐ I am a non immigrant whose visa for entry, or application for visa for entry, is related to such employment in the United States
- ☐ I am a qualified alien under the Federal Immigration and Nationality Act

NOTE: If you are an alien lawfully admitted into the U.S. for permanent resident OR non-immigrant whose visa/application for visa for entry is related to such employment in the US, you must submit evidence of lawful permanent residence and/or immigration status which may include a copy of:

1. An Alien Registration Receipt Card (Form I-551, otherwise known as a "Green Card");
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
3. A document showing an Alien Registration Number ("A#"); with visa status or
4. A Form I-94 (Arrival-Departure Record) with visa status.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete;
3. I am of good character;
4. I have not committed any act that would be grounds for denial under Neb. Rev. Stat. 38-178 and/or 38-179. If you have committed an act(s), you must provide an explanation of all such act(s); and
5. I have completed the required continuing education within the preceding 36 months pursuant to 172 NAC 11 or have applied for a waiver of continuing education

Print Name: _____

_____ _____

(Signature of Applicant) (Date)

Please provide the following information so we may quickly contact you, if necessary.

Phone: (optional) _____ Fax: (optional) _____

Email address (optional) _____